DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1182 (Rev. 09/02)

STATE OF WISCONSIN

WISCONSIN MEDICAID
DECLARATION OF SUPERVISION FOR NONBILLING PROVIDERS

SECTION I — PROVIDER INFORMATION

Name and Credentials — Nonbilling Provider	Wisconsin Medicaid Provider Number
Address — Nonbilling Provider	**Telephone Number — Nonbilling Provider**

I, _____, direct Wisconsin Medicaid to make checks payable to
(Name — Provider)

_____ for all claims payments for services performed by me
(Name — Clinic or Supervisor)

under Wisconsin Medicaid since Wisconsin Medicaid cannot reimburse me.

I understand that this payment arrangement will continue in effect until Wisconsin Medicaid receives a new Declaration of Supervision form from me. When my supervisor, employer, or work address changes, I will immediately send this completed form to Wisconsin Medicaid.

SIGNATURE — Nonbilling Provider (required)	Date Signed (required)

SECTION II — SUPERVISOR INFORMATION

Name — Supervisor	Wisconsin Medicaid Provider Number	IRS Number — Employer
Address — Supervisor		**Telephone Number — Supervisor**

I, _____, am supervising the work of _____.
(Name — Supervisor) (Name — Provider)

The effective starting date of my supervision was _____. I hereby acknowledge and
(Supervisor's Effective Starting Date)
agree to the above payment arrangement.

I understand that if my name is indicated in Section I above, Wisconsin Medicaid payment for services provided by the above provider will be payable to me directly and will be reported under the IRS number written above. If I discontinue supervision of the above provider, I understand that I must notify Wisconsin Medicaid at the address at the bottom of this page.

SIGNATURE — Supervisor	Date Signed

Mail to:
Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

For more information, contact Provider Services at (800) 947-9627 or (608) 221-9883.

Reset Form